Allianz AYUDHYA

FlexCare
Plan Guide

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Your Plan Guide

We would like to welcome you and thank you for choosing a FlexCare plan. We aim to provide you with an International Healthcare Plan you can rely on. To do this, it is important that you fully understand how your plan works. This Plan guide, together with your Table of benefits, explains what is, and is not, covered under the FlexCare plan and any of the following modules that have been chosen:

- Outpatient
- Wellness
- Dental/Optical
- Maternity
- Personal Accident

See the 'Definitions' section for more information on your underwriting terms, as shown on your Certificate of insurance. Also see BE1 and BC5 for more information.

This Plan guide will also give you important information about managing these plans.

Please spend some time reading carefully through this Plan guide to make sure that you are completely satisfied with the cover we are providing and that the cover meets your needs. If you have any questions about the information in this Plan guide or any questions you think it does not answer, please contact us and we will be more than happy to help.

Some words and phrases used in this Plan guide and your Table of benefits have specific meanings that are relevant to your plans. We have highlighted them in bold print and defined them in the 'Definitions' section of this Plan guide.

This plan is issued by Allianz Ayudhya General Insurance Pcl.

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Individual plans

The Individual application, Table of benefits, Certificate of insurance and this Plan guide form the contract of insurance with us and you must read them together.
The currency of your FlexCare plan will be Thai Baht. Premiums must be paid in the same currency as your plans.
We can change any of the general conditions, benefit conditions, benefit exclusions or other terms and conditions in this Plan guide at the beginning of the plan year. We can also change the premiums and any discounts or surcharges at the beginning of the plan year. We will tell the planholder about any changes before the plan renewal date.

Definitions

Wherever we use the words 'including', 'include', 'in particular', 'for example' or any similar expression any following information is given as an example only, not a full list, and will not limit the sense of the words, description, definition, phrase or term before those words.

Abuse – the excessive use of alcohol, drugs or any other intoxicating substance. This includes use of drugs in a manner or in quantities other than as directed or prescribed on medical authority or for a reason other than that for which it was originally prescribed.
Accident – any involuntary, sudden or unexpected event resulting in a bodily injury to you.
Acute – a medical condition that responds to treatment, which aims to return you to your previous state of health or leads to your full recovery.
Area of cover – the geographic area or areas of the world in which you must receive treatment or services for your plan to apply. Your area of cover is shown on your Certificate of Insurance.
Benefit – the cover provided by your plan and any extensions or restrictions shown in your Plan guide, Certificate of insurance or Table of benefits.
Birth defect – any deformity, abnormality or disability, or caused during childbirth.
Bodily injury – any physical harm or damage to you
Business colleague – an associate who is employed by the same company as you.
Card – Visa or Master Card (credit card only).
Chronic – a medical condition that has one or more of the following characteristics:

- needs ongoing or long-term monitoring through consultations, examinations, checkups or tests;
- needs ongoing or long-term control or relief of symptoms;
- needs rehabilitation or special training to cope with it;
- continues indefinitely;
- has no known cure;
- comes back or is likely to come back.

Claim – when you or your agent, personal representative, assignee or trustee in bankruptcy seek payment or settlement under the terms and conditions of the plan.

Client – An insured person

Clinic - Any medical facility which provides medical services, where patients cannot be accommodated overnight, and which is registered to operate as a clinic in accordance with applicable laws of the jurisdiction in which the clinic is located.

Close family member – a son, daughter, stepson, stepdaughter, legally adopted son, legally adopted daughter, husband, wife, partner, parent, step-parent, legally adoptive parent, parent-in-law, grandparent, grandchild, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law or legal guardian.

Co-insurance/Co-pay/Copayment – the percentage of costs that you must pay for a covered claim.

Congenital abnormality – A medical condition that is present at birth or is believed to have been present since birth, whether it is inherited or caused by an environmental factor.

Country, where you live, country where a member lives – the country you live in for most of the time, usually for a period of at least six months during a plan year.

Critical – a medical condition that is unstable and serious, where the outcome cannot be medically predicted, prognosis is uncertain and the person may die.

Date of joining – when you first became a member on the plan.

Daycare treatment – Planned treatment received in a hospital or day-care facility during the day for four hours or more, including a hospital room and nursing, that does not medically require the patient to stay overnight and where a discharge note is issued.

Deductibles – It is the part of the cost that is payable by you and that we deduct from the amount we will pay. Where deductibles apply, they are applicable to all benefits and are payable per person per Insurance Year, unless your Table of Benefits states otherwise.

Dental – that which affects the teeth and gums.

Dependant – Your spouse or partner and unmarried children that are named as dependants on your Insurance Certificate. Children are covered up to the day before their 18th birthday; or up to the day before their 24th birthday if they are in full-time education.

Diagnostic tests and procedures – a medically necessary test or examination to investigate the cause of your symptoms.

Emergency – a sudden, unexpected acute medical condition or an unexpected acute episode of a chronic medical condition that, without treatment within 24 hours of onset, could result in death or serious damage to bodily functions.

Emergency out-patient treatment – Treatment received in a casualty ward or emergency room within 24 hours of an accident or sudden illness, where there is no medical necessity for you to occupy a hospital bed. If your policy includes an out-patient module, it will cover you for out-patient treatment in excess of the limit for the 'Emergency out-patient treatment' benefit. In that case, the out-patient plan terms will apply.

Emergency out-patient dental treatment – Treatment received in a dental surgery or hospital emergency room for the immediate relief of dental pain caused by an accident or an injury to a sound natural tooth. Treatment may include pulpotomy or pulpectomy and the subsequent temporary fillings, limited to three fillings per Insurance Year. Treatment must take place within 24 hours of the emergency event. It does not include any form of dental prostheses, permanent restorations or the continuation of root canal treatment. However, if your policy also includes a Dental Plan, it will cover dental treatment in excess of the limit for the 'Emergency out-patient dental treatment' benefit. In that case, the Dental Plan terms will apply.

Emergency treatment outside area of cover - Treatment for medical emergencies which occur during business or holiday trips of up to six weeks outside your area of cover. It includes treatment required due to an accident or the sudden beginning or worsening of a severe illness which presents an immediate threat to your health.

Treatment by a doctor must start within 24 hours of the emergency event. Cover is not provided for curative or follow-up non-emergency treatment, even if you are deemed unable to travel to a country within your geographical area of cover. Nor does it extend to charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth. You must tell us if you are going to be outside your area of cover for more than six weeks.

End date – the last day you have cover under a plan.

FlexCare plan – the healthcare insurance plan

FMU, Full Medical Underwriting – the process that we use to assess your medical history and decide the special terms we offer you. Cover will still be governed by the benefits, terms and conditions of your plan with us.

Hazardous pursuit – any activity or sport that places you at an increased risk of suffering a medical condition or making an existing medical condition worse, including but not limited to:

- Mountain sports such as abseiling, mountaineering and racing of any kind (except for racing on foot).
- Snow sports such as bobsleigh, luge, mountaineering, skeleton, skiing off-piste and snowboarding off-piste.
- Equestrian sports such as hunting on horseback, horse jumping, polo, steeple chasing or horse-racing of any kind.
- Water sports such as potholing (solo caving) or cave diving, scuba diving to a depth of more than 10 metres, high diving, white water rafting and canyoning.
- Car and motorcycle sports such as motorcycle riding and quad biking.
- Combative sports.
- Air sports such as flying with a microlight, ballooning, hang gliding, paragliding, parascending and parachute jumping.
- Various other sports such as bungee jumping.

Home country – the country you are from as given to us on your application.

Hospital – a legally licensed facility providing treatment under the laws of the country in which it is located.

Inherited – a medical condition which is hereditary.

In-house doctor – a doctor who is employed by the hospital, is considered a permanent member of staff and charges in line with hospital tariffs.

In-patient treatment – treatment at a hospital where you need to stay in a bed for one or more nights.

Long-term Care – Care over an extended period of time after the initial acute/curative treatment has been completed. This usually occurs for a chronic condition or disability requiring uninterrupted /continuous medical care, or where treatment options are limited to the existing level of care. Long-term care can be provided at home, in the community, in a hospital, a long-term care facility or in a nursing home.

Policyholder – the person who is named first on a valid Certificate of insurance.

Material fact – information, as follows, which is likely to influence us in the assessment, acceptance or renewal of a plan, or in making any changes to it:

- about you, your lifestyle, health or medical conditions, that we have asked you questions about;
- about the planholder and any insured persons, including dependants, where we have asked the planholder questions; or
- that you or the planholder have chosen to give to us.

If there is any doubt about whether a fact is material, for your own protection, you must tell us.

Medical condition – signs or symptoms, injury, illness, sickness or disease.

Medical necessity, medical necessary – treatment prescribed by your medical practitioner attending specialist which is appropriate for your medical condition and is in line with accepted medical standards.

Medical practitioner – a person who is registered and licensed to practise medicine in the country where treatment is provided and has obtained the primary degrees in medicine and surgery following attendance at a recognised medical school listed within the World Directory of Medical Schools published by the World Health Organisation.

Natural teeth – any teeth that are original and organic, not artificial implants or replacements.

Necessary and Reasonable Expenses – the average cost of treatment, expertise or services given by similar types of provider:

- within the same country or geographical region; and
- based on our experience and knowledge.

Nurse – a person who is qualified in nursing, currently practicing and on the professional register of nursing in the country where treatment is provided.

Orthodontic treatment – The use of devices to correct malocclusion (misalignment of your teeth and bite). We only cover orthodontic treatment that meets the medical necessity criteria described below. As the criteria is very technical, please contact us before starting treatment so we can verify if your treatment meets the criteria.

Medical necessity criteria:

- Increased overjet > 6mm but <= 9 mm
- Reverse overjet > 3.5 mm with no masticatory or speech difficulties
- Anterior or posterior crossbites with > 2 mm discrepancy between the retruded contact position and intercuspal position
- Severe displacements of teeth > 4
- Extreme lateral or anterior open bites > 4 mm
- Increased and complete overbite with gingival or palatal trauma
- Less extensive hypodontia requiring pre-restorative orthodontics or orthodontic space closure to obviate the need for a prosthesis
- Posterior lingual crossbite with no functional occlusal contact in one or more buccal segments
- Reverse overjet > 1 mm but < 3.5 mm with recorded masticatory and speech difficulties
- Partially erupted teeth, tipped and impacted against adjacent teeth
- Existing supernumerary teeth

You will need to send us some supporting information to show that your treatment is medically necessary and therefore covered by your plan. The information we ask for may include, but is not limited to:

- A medical report issued by the specialist, stating the diagnosis (type of malocclusion) and a description of your symptoms caused by the orthodontic problem.
- A treatment plan showing the estimated duration and cost of the treatment and the type/material of the appliance used.
- The payment arrangement agreed with the medical provider.
- Proof of payment for orthodontic treatment.
- Photographs of both jaws clearly showing dentition before the treatment.
- Clinical photographs of the jaws in central occlusion from frontal and lateral views.
- Orthopantomogram (panoramic x-ray).
- Profile x-ray (cephalometric x-ray).
- Any other document we may need to assess the claim.

We will only cover the cost of standard metallic braces and/or standard removable appliances. However, we'll cover cosmetic appliances such as lingual braces and invisible aligners up to the cost of metallic braces, subject to the 'Orthodontic treatment' benefit limit.

Our, us, we – the insurer as shown on the Certificate of Insurance.

Out-patient surgery – Out-patient medical procedures that do not require an overnight stay, including biopsies, that require an incision to the member's body for the purpose of providing therapeutic treatment.

Out-patient treatment – treatment in a hospital, consulting room or clinic when you do not need a bed.

Palliative treatment – any surgical or medical services aimed to relieve the symptoms rather than to cure, stop, reverse or delay progression of the medical condition causing them.

Partner – A person you have lived with in a conjugal relationship for a continuous period of 12 months.

Periodontic treatment – dental treatment related to gum disease.

Physiotherapist – a person who is qualified to practise physiotherapy and is licensed in the country where treatment is provided.

Plan – the contract between the planholder, you and us.

Planholder – the person we have issued the plan to as named on a valid Certificate of insurance.

Plan start date – the date the plan begins each year.

Plan year – a period of 12 months, from the plan start date, as shown on a valid Certificate of insurance.

Pre-authorisation – the process you must follow to obtain approval from us before receiving treatment or services, or incurring costs.

Pre-existing – any medical condition or related medical condition which has had one or more of the following characteristics:

- clearly showed itself;
- you had signs or symptoms of;
- you asked for advice about;
- you received treatment for;
- to the best of your knowledge, you were aware you had.

You must also read General Condition GC2, Benefit Condition BC5.

Prescribed medical aids – Any device that is prescribed and medically necessary to enable you to carry out everyday activities. Examples include:

- Biochemical aids such as insulin pumps, glucose meters and peritoneal dialysis machines
- Motion aids such as crutches, wheelchairs, orthopaedic supports/braces, artificial limbs and prostheses
- Hearing and speaking aids such as an electronic larynx
- Medically graduated compression stockings
- Long-term wound aids such as dressings and stoma supplies

We do not cover costs for medical aids that form part of palliative care or long-term care.

Preventative services – medical services where no medical condition or symptoms are present.

Psychiatric – that which affects your mind, mental function or emotions, whether the cause is organic, traumatic or reactive.

Related medical condition – a medical condition that in the opinion of both your medical practitioner or specialist, and us is:

- a direct or indirect result of another medical condition;
- associated with another medical condition; or
- an associated risk factor of another medical condition.

Renewal date – the anniversary of the plan start date as shown on a valid Certificate of insurance.

Routine health check – diagnostic tests and procedures where no medical condition or symptoms are present.

Southeast Asian countries – Cambodia, East Timor, Indonesia, Laos, Malaysia, Myanmar (Burma), Philippines, Singapore, Thailand, Timor-Leste, Vietnam

Southeast Asia excluding Singapore: Cambodia, East Timor, Indonesia, Laos, Malaysia, Myanmar (Burma), Philippines, Thailand, Timor-Leste and Vietnam.

Southeast Asia including Singapore: Cambodia, East Timor, Indonesia, Laos, Malaysia, Myanmar (Burma), Philippines, Singapore, Thailand, Timor-Leste and Vietnam.

Specialist – a medical practitioner who is practising and has a recognised:

- certificate of higher specialist training;
- consultant appointment or equivalent; in the relevant field of medicine in the country where treatment is provided.

Start date – the date you join the plan.

Terminal – the end stages of a medical condition where life expectancy is considered to be days or weeks and only palliative treatment is given.

Therapist – an osteopath, chiropractor, homeopath, podiatrist, acupuncturist or Chinese herbalist who is qualified and licensed in the country where treatment is provided.

Treatment – any surgical or medical services, including diagnostic tests and procedures, that are needed to diagnose, relieve or cure a medical condition.

Visiting doctor – a medical practitioner who is not employed by the hospital, but has a contract to use the hospital facilities and may have different charges to the hospital tariffs.

You, your, yourself – a person who has met the eligibility criteria of the plan and is named on a valid Certificate of insurance.

Worldwide excluding USA: All countries except the USA. We may be unable to cover treatment received in countries which are subject to international sanctions (e.g. Iran, North Korea, Russia). Sanctioned countries vary over time so we advise all insured persons to check the status of destination countries with us prior to travel.

Cooling off period

If you feel a plan does not meet your needs, the planholder may cancel it. The planholder must tell us in writing by letter, fax or email within 30 days of receiving the Table of benefits, Certificate of insurance and Plan guide, or the date of joining, whichever is later. As long as no claims have been made by any member on the plan, the premium received will be refunded in full.

If any claims have been made, the cancellation will be governed by the 'Cancellation' section in this Plan guide.

Premiums can only be refunded to the account they were originally paid from. The planholder will be responsible for:

- any shortfall as a result of exchange rate differences; and
- any associated bank charges.

The stamp duty or any specific taxes will not be refunded in any situation.

If the planholder decides to cancel a plan after the 30-day period, the cancellation will be governed by the 'Cancellation' section in this Plan guide.

Individual Eligibility

Your eligibility depends on us accepting the application, including the medical questionnaire if your underwriting terms are FMU.

The FlexCare plans are available to people of all nationalities, including dependants, who reside in Thailand for 180 days or more in each policy year.

Plans may not meet specific visa requirements. Cover may also be illegal under local laws. It is the planholder's responsibility to ensure that any plans chosen meet your needs.

All dependant children on a plan must be unmarried. Dependant children aged 18 to 24 must be in continuous full-time education at their start date.

The minimum age of a planholder is 18. If none of the members to be included on the plan are 18 or above at the date of application, the application will be subject to our acceptance, and their parent or legal guardian must apply for them. The parent or legal guardian will act as the planholder, but will not have cover under the plan. FlexCare plan premiums will be based on the adult rate of 18 to 25 years for all members included on the plan. No discounts will apply.

You cannot be older than 65 at your start date.

Your coverage ends at age 70 unless you have had continuous cover under the FlexCare program for at least 5 continuous years and that all your premiums have been paid.

The planholder and their dependants must have the same area of cover.

All plan modules are only available with the same area of cover as the inpatient plan.

The maternity module is only available to female members aged 18 to 44 at entry. Once members reach the age of 46 during a plan year, their maternity cover will not be renewed.

Personal accident cover is available for managerial, clerical and administrative occupations only. See benefit condition BCPA1 for more information.

We can refuse cover on any of our plans for any reason. We may provide cover under our plans with any special terms that we may set. Any special terms will be shown on the Certificate of insurance.

Plan start date

If your FlexCare plan underwriting terms are FMU, cover on the FlexCare plan will begin as soon as:

- we receive the completed application and all required documents, in the case that no medical conditions are declared.
- we receive the planholder's acceptance of the special terms offered in the quotation, in the case that medical conditions have been declared.

We will tell the planholder the start date in writing.

We cannot backdate cover under any circumstances. All plans will continue for 12 months until the next renewal date.

The premiums and benefits applied to a plan will be those in force at the plan start date.

Premiums

Each plan is a yearly contract.

The planholder must choose how often your FlexCare plan premiums are paid from the payment options available for that plan type. They must choose this at application or renewal and it will apply throughout the entire plan year.

The planholder is responsible for paying all premiums. Premiums must be paid in Thai Baht. The premium will be returned if payment is received in a different currency to the currency of your plans.

The planholder will be responsible for:

- any shortfall as a result of exchange rate differences; and
- any associated bank charges.

FlexCare plan premiums are based on the age of the planholder and each dependant at the plan start date.

All cover is subject to our eligibility criteria.

We must receive all premiums, including any taxes that apply, on or before the premium due dates.

Methods of Payment

Premiums must be paid in Thai Baht.

For yearly payments, premiums can be paid by:

- bank transfer; or
- cheque
- credit card (Visa/Mastercard)

For payments made every month or every three months, premiums can only be paid by card.

Bank transfers and cheques

See the individual application or renewal quotation for payment details. When making a payment, the planholder must give their full name and the quotation number or FlexCare plan number as the reference.

Card

Please make credit card payments via the payment link provided. Please do not send card details by email. Email and internet messages cannot be guaranteed to be completely secure, as personal information can be intercepted, lost or stolen. Card details sent by email will not be processed.

The planholder will be told in writing if, for any reason, premiums cannot be collected. Attempts to collect the premium will continue unless the planholder gives alternative instructions. This may mean that more than one premium needs to be collected on the next collection date. See the 'Unpaid or late premiums' section for more information.

The planholder is responsible for providing up to date card details. The planholder must advise any changes to the card details to make sure that any premiums can be collected.

Unpaid or late premiums

The planholder must make sure premiums are paid on or before the due date. We will tell the planholder, in writing, if payments are not made on time.

We will not approve or pay any claims until the payments are up to date.

We will cancel a plan if payment is not received within 30 days of the premium due date. If we cancel a plan, the planholder will have to apply for a new plan. We will charge the premiums in force at that time and the cover may have new terms.

Adding dependants

To add a dependant to your plan after the plan start date, please contact us and we will let you know the information you will need to provide to us which may include completing an application form for the dependant, and how we may change your premium as a result. We will send you your revised Certificate of Insurance and the new dependant's Member ID Card each time we add a dependant to your plan.

Start dates for added dependants

Newborns may be added to a parent's policy subject to the following conditions:

- An application form is submitted within 30 days from birth of the baby with the birth certificate or delivery record. If the application is accepted, cover will start at birth.
- If we're not notified within 30 days then, coverage will start on the date of application if no medical conditions are declared; or we will (based on a complete application form for the dependant) either cover the dependant from the date on which you accept any terms we offer in relation to such dependant or decline to add the dependant to your plan. If we decline to add a dependant, we will explain to you the reason for this in writing.

Limit for multiple-birth babies, all babies born by assisted conception, surrogacy, adopted and fostered children. There is a limit for in-patient treatment that takes place in the first three months following birth if the baby:

- was born as a result of medically assisted reproduction.
- was born by surrogacy.
- is adopted.
- is fostered.

This limit is THB 1,344,000 per child. Out-patient treatment is paid under the terms of the Out-patient Plan.

To add any other dependant to your plan:

- We will cover the dependant from the date of application or from a later date, within 30 days of application, that you may request if there are no medical conditions declared; or
- We will (based on a complete application form for the dependant) either cover the dependant from the date on which you accept any terms we offer in relation to such dependant or decline to add the dependant to your plan. If we decline to add a dependant, we will explain to you the reason for this in writing.

The terms of the plan will apply to any dependant you add.

Removing dependants

With our agreement the planholder may remove a dependant from a plan after the plan start date. The planholder must make the request in writing. The last day of cover will be the date that we receive the request, or a future date the planholder has given.

Any premiums received for the remainder of the plan year will be refunded on a pro-rata basis.

No claims will be paid for any costs incurred after the last day of cover.

Premiums may change in line with any agreed requests.

If dependants are removed from more than one plan, any pro-rata refund or outstanding premium due on each plan will be combined.

If any refund is due, this can only be refunded to the account it was originally paid from. The planholder will be responsible for:

- any shortfall as a result of exchange rate differences; and
- any associated bank charges.

The Stamp duty or any specific taxes will not be refunded in any situation.

We will send the planholder a revised Certificate of insurance showing the changes and any special terms that may apply.

Making plan changes

When making any request for changes to a plan, including plan modules, the planholder must also tell us all material facts. If there is any doubt about whether a fact is material, for your own protection, the planholder should tell us. See general condition GC2 for more information.

If you change your address the planholder must tell us in writing by letter, fax or email. If your new address is in a different country, we will consider this to be the country where you live unless the planholder tells us otherwise.

If the planholder wants to change the area of cover on the FlexCare plan they must tell us in writing, giving the reason for the change in circumstances. With our agreement this change can be made at policy renewal only and, if coverage is increased, new waiting periods will apply for maternity benefits.

We will send the planholder a revised Certificate of insurance if your area of cover changes. If your area of cover changes, we will also send a new membership card. The Certificate of insurance and membership card will show the changes and any special terms that may apply. Premiums, taxes and benefit limits may change in line with any agreed requests.

The planholder cannot make changes to:

- the FlexCare plan type;
- deductibles, co-insurance or how often the premiums are paid on the FlexCare plan

during the plan year. With our agreement these changes can be made at the next plan renewal date. The planholder must tell us about the changes in writing by letter, fax or email before the plan renewal date. Premiums, taxes and benefit limits may change in line with any agreed requests.

Benefit modules cannot be added during the plan year. With our agreement these can be included from the next plan renewal date. The planholder must apply in writing before the plan renewal date. When making the application, the planholder must also tell us all material facts. If there is any doubt about whether a fact is material, for your own protection, the planholder should tell us.

Renewal

With our agreement the planholder may renew the FlexCare plan each year.
If the planholder wants to renew, they must tell us in writing before the renewal date.
The planholder must tell us all material facts before the renewal date. If there is any doubt about whether a fact is material, for your own protection, the planholder should tell us. See general condition GC2 for more information.
We may change the definitions, benefits, general conditions, benefit conditions and benefit exclusions that apply to the FlexCare plan. Any changes will be sent to the planholder together with the renewal quotation at least six weeks before the renewal date. Renewal premiums must be paid on or before the renewal date or in accordance with the payment schedule specified by us.
FlexCare plan renewal premiums are based on the age of the planholder and each dependant at the renewal date, increases in medical inflation, portfolio performance and the plan type chosen.
All cover is subject to our eligibility criteria.
A child will no longer be eligible as a dependant under any plan at the next renewal date if any one or more of the following apply:

- they marry;
- they are not in continuous full-time education and they are 18 to 24; or
- they reach the age of 25.

With our agreement they can apply to have their own FlexCare plan by completing an Individual application. As long as there is no break in their cover with us, their date of joining will stay the same. Their application will be governed by the definitions, benefits, general conditions, benefit conditions and benefit exclusions in force at their new plan start date.

Cancellation

If the planholder wants to cancel a plan, they must confirm in writing by letter, fax or email.
Please see the 'Cooling off period' section if a plan is being cancelled within 30 days of receiving the Table of benefits, Certificate of insurance and Plan guide, or the date of joining, whichever is later, and no claims have been made, or will be made, on the plan.
If the 'Cooling off period' section does not apply, the last day of cover will be the date that we receive the written confirmation, or on a future date given to us.
Any premiums received for the remainder of the plan year will be refunded on a pro-rata basis.
No claims will be paid for any costs incurred after the last day of cover.
If more than one plan is cancelled, any pro-rata refund or outstanding premium due on each plan will be combined.
If any refund is due, this can only be refunded to the account it was originally paid from.
The planholder will be responsible for:

- any shortfall as a result of exchange rate differences; and
- any associated bank charges.

The Stamp duty or any specific taxes will not be refunded in any situation.
The planholder must return the Certificate of insurance when they cancel a plan. They must also return all membership cards if the FlexCare plan is cancelled.

Death

If the planholder dies we will offer their dependants (spouse, partner, dependant 20+) continued cover if we receive a signed Individual application from them within four weeks of the date of death.
If the dependants is not 20+, they need to have the parents / parents appointed by law to be their new planholder.

General conditions, benefit conditions and benefit exclusions

The FlexCare plans are governed by the general conditions shown below. Claims will only be paid under a plan if you meet these general conditions and benefit conditions.
Extra benefit conditions also apply to the Maternity and Personal accident benefits. See the 'Extra benefit conditions and benefit exclusions' section for more information.

General conditions

GC1 The planholder must tell us immediately in writing by letter, fax or email about any important change that affects information given in connection with the application for cover under a plan, for example:

- you change your name or occupation;
- there is a change to planholder details;
- you plan to engage in any hazardous pursuits; or
- you change your address.

If your new address is in a different country, we will consider this to be the country where you live unless the planholder tells us otherwise.
After we have been told about a change, we have the right to reassess your cover. We can change any of the terms or cancel the plan. Any claim related to a change in risk that the planholder has not told us about may be reduced or rejected, or the plan may be cancelled.
GC2 The planholder must tell us all material facts before we accept an application, make changes to a plan or renew a plan. The planholder must check that any material facts are correct. You must check that any material facts about you are correct.

If there is any doubt about whether a fact is material, for your own protection, the planholder should tell us.

If we find out that the planholder has not told us about all material facts we can cancel the plan or apply different terms to the plan.

GC3 If you make a claim that you know is false or fraudulent, we will refuse the claim. If any payment has already been made, we will recover any costs from the planholder. We will cancel cover from a date given by us.

GC4 We will send all correspondence about a plan to the planholder.

GC5 When handling your claim we will always:

- communicate directly with you if you are aged 18 or over;
- communicate directly with the main member if you are under 18;

unless you or your personal representative give us explicit consent to contact any other individual about your claim in accordance with our data protection policy.

GC6 If you need to make a claim for reimbursement, you must follow your Claims procedures and send the following information as soon as possible. For submission of paper documents:

- the original itemised bill;
- the original receipt;
- the fully completed Claim form;
- a copy of the prescription; and
- a copy of the investigative tests results where relevant (e.g. blood tests, x-rays, ultrasound, etc).

<u>For online claims submission:</u>

If you would like to make an online claim for reimbursement, you may do so using the Allianz Ayudhya My Health application. Online claims submissions are subject to the following limitations:

- Outpatient treatment claims: up to a maximum of THB5,000 per claim and 20 claims per policy-year.
- Inpatient treatment claims: up to a maximum of THB20,000 per inpatient admission and 2 claims per policy-year.

Clear and legible scans or photos of the following documents are required:

- The original receipt
- The original medical certificate
- Other relevant supporting documents such as: a copy of the prescription; a copy of the investigative test results (e.g. blood tests, x-rays, ultrasound, etc).

We reserve the right to request the original documents for any reason.

This information is required to support your claim. If this information is not sufficient, we may ask for more information to support your claim. You must provide this additional information or your claim may not be paid.

Original receipts should be retained for at least 12 months from the date of issue.

GC7 We have the right to instruct a specialist of our choice to examine you as we see necessary to support a claim.

GC8 If we reject a claim under a plan, for any reason, you will have to prove that the claim is covered under the plan.

GC9 Costs incurred for consultations, treatment, medication and therapy are eligible for cover when administered to an insured person during the policy period only, regardless of the date prescribed by a medical professional.

GC10 If you attend a hospital, clinic or any other facility where direct billing or cashless arrangements are in place, and the claim for this is subsequently found to be ineligible, we have the right to recover the full amount of the claim from you or the planholder. Payment of a claim is not an indication of our acceptance of liability for the claim or confirmation that further costs for the same medical condition or any related medical condition will be met.

GC11 If there are other insurance plans or policies that cover a claim, including any reciprocal health insurance arrangements, and they have any of the same, or equivalent benefits, only our share of the claim will be paid under your plan with us, after:

- you have paid any deductibles or co-insurance that apply on any of the other plans or policies; and
- you have paid any deductible or co-insurance on your plan with us.

GC12 We can make an administration charge to replace or reissue plan documents or membership cards.

GC13 The planholder must tell us immediately in writing about any proceedings or right of action against any other party, due to any circumstances which led to a claim under a plan. The planholder must continue to keep us informed in writing and take all steps we reasonably need, for us to take proceedings against the other party.

GC14 The planholder must tell us about any negotiations or settlement discussions that you enter into with any other party about any action which leads to a claim under a plan. You must not agree to a settlement with any party before we give our written agreement.

GC15 If you want to take legal action against us in respect of a plan, you must do so within the relevant time bar according to Thai law.

GC16 The FlexCare plan and modules are governed by and shall be construed in accordance with the laws of Thailand and shall be subject to the exclusive jurisdiction of the courts of Thailand.

GC17 Any translated versions of our documents that we issue are for your information only. In the case of any dispute or discrepancy of wording or interpretation, the English version will apply.

Benefit conditions

BC1 All treatment must be given by medical practitioners, specialists, nurses or therapists with the aim to cure or substantially relieve medical conditions.

BC2 You or your personal representative must request pre-authorisation for any in-patient treatment, daycare treatment, medical evacuation, compassionate emergency visit, or preparation or transportation of your body or mortal remains, before it takes place. Once you or your personal representative have received our approval, we will settle all covered costs directly with the providers. If you or your personal representative do not receive our approval before it takes place, we will only approve the costs we would have negotiated if we had been involved and given our approval.

BC3 Hospital accommodation will be paid up to the cost of a standard single room with a private bathroom. If a standard single room is unavailable, we will cover the cost of upgrade to a room one level above standard. This will include your hospital meals.

BC4 If a local situation makes it impossible, dangerous or not practical to enter a specific location or country, we may be unable to arrange a medical evacuation.

BC5 If a claim is made that we believe is for a pre-existing medical condition, we will reject the claim if you did not tell us about the medical condition when we asked about it on the application, or we have not accepted it.

BC6 Only necessary and reasonable expenses will be paid for claims. Any costs above the relevant limits shown in your Table of benefits will not be paid. If any costs are not necessary and reasonable expenses, or are above the limits shown in your Table of benefits, you will have to pay the difference.

BC7 If you choose to use a visiting doctor instead of an in-house doctor, in a hospital, clinic or any other facility where direct billing or cashless arrangements are in place, only necessary and reasonable expenses will be paid. If the visiting doctor's costs are not necessary and reasonable expenses and not in line with the in-house doctor's costs, you will have to pay the difference.

BC8 If you move to a plan where a lifetime limit applies to a benefit, any amount previously paid under the same, or equivalent benefit:

- on any one or more plans;
- regardless of any previous benefit limit; and
- whether or not there has been a break in your cover;

will be deducted from the current lifetime limit on the benefit.

BC9 Physiotherapy must be referred by a medical practitioner or specialist.

BC10 Complementary treatment must be referred by a medical practitioner or specialist.

BC11 All psychiatric treatment and psychotherapy must be given by medical practitioners, psychiatrists or qualified and registered psychotherapists or psychoanalysts.

BC12 The normal pregnancy and childbirth benefit covers no more than one routine antenatal ultrasound scan in each trimester of a normal uncomplicated pregnancy. If any more ultrasound scans are needed, your medical practitioner must confirm the reasons in the Claim form so we can consider cover. The benefit also covers 12 routine antenatal visits during a normal uncomplicated pregnancy. If any more antenatal visits are needed your medical practitioner must provide the reasons in the Claim form so we can consider cover.

The benefit covers the following for the newborn child:

- one physical examination;
- vitamin K, hepatitis B and BCG vaccinations;
- routine blood tests for PKU, congenital hypothyroidism and G6PD;
- one hearing examination; and
- necessary and reasonable expenses of accommodation costs for no more than four nights, if the mother is admitted and not suffering any complications.

BC13 If we receive new information that shows a claim we have already approved is not eligible, no costs will be paid. If any costs have already been paid, we will recover these from you or the planholder and no further costs will be paid. Any approval we have given during the pre-authorisation process may also be withdrawn.

Benefit exclusions

The FlexCare plans do not cover claims for, arising from or connected with the following benefit exclusions unless shown on your Table of benefits, or agreed by us in writing.

BE1 A medical condition or symptom that you were aware of before your start date unless we were given all the information we asked for in the application and we have not specifically excluded the medical condition or symptom as shown in your underwriting offer and any policy endorsements.

BE2 Costs that exceed a limit shown on your Table of benefits.

BE3 A benefit not included on your plan.

BE4 A benefit not included on your plan at the time the costs are incurred, even if the benefit was included in any previous plan year.

BE5 A benefit included on your plan, if you have not completed the duration of shown on your Table of benefits.

BE6 Any journey made specifically for the purpose of receiving medical treatment, unless you have requested pre-authorisation and we have given our approval.

BE7 Non-emergency transportation.

BE8 Burial, cremation, or the costs of moving your body or mortal remains, if you die in your home country.

BE9 Any journey, activity, action or pursuit carried out against the advice of a medical practitioner, specialist/ nurse or therapist.

BE10 Treatment given, or referrals made by, a medical practitioner, specialist, nurse or therapist who is in any way related to you, and self-prescribed treatment or self-referral if you are a medical practitioner, specialist or therapist.

BE11 Alcohol, drug or any other intoxicating substance abuse, any addictive condition of any kind and any medical condition arising directly or indirectly from any such abuse or addictive condition.

BE12 You being under the influence of alcohol, drugs or any other intoxicating substance.

BE13 Male to female or female to male gender reassignment.

BE14 Tests or treatment for, or because of, sexually transmitted infections.

BE15 Experimental or unproven treatment, unless you have requested pre-authorisation and we have given our approval.

BE16 Bone marrow transplants, the costs of finding and obtaining an organ, costs as a result of removing an organ from a donor, any costs related to the transplant of an organ that is not obtained in accordance with the World Health Organisation's guidelines, costs of removing an organ from you to transplant it into another person, and any resulting complications.

BE17 Cryopreservation, implantation or re-implantation of living cells or living tissue, whether taken from your own body or provided by a donor. Costs of removing living cells or living tissue from you to implant or re-implant into another person, and any resulting complications.

BE18 Foetal treatment.

BE19 Terminating a pregnancy.

BE20 Congenital abnormalities or birth defects, unless we agree in writing to provide cover for these conditions.

BE21 Suicide, attempted suicide or any deliberate, self-inflicted medical condition.

BE22 Putting yourself in needless danger, except in an attempt to save human life.

BE23 Any medical condition suffered by military, naval or air force personnel engaging in any military, naval or air force operation or exercise.

BE24 Any medical condition you suffer as a result of taking part in, or engaging in, any one or more of the following:

- an illegal or criminal act;
- military activity, war, riot, revolution, strike, lock-out or civil commotion;
- terrorism, usurped power; or
- any similar event.

BE25 Contamination from biological, chemical or nuclear materials, including waste products from the combustion of nuclear fuel. Any biological, chemical or nuclear weapon of mass destruction, whether or not as the result of an explosion.

BE26 Treatment received and costs incurred outside your Area of cover.

BE27 You using a weapon or firearm for any purpose, or engaging in any professional sports when you receive payment for that sport as the main source of your income.

BE28 Sleep apnoea, sleep-related breathing disorders, snoring or insomnia.

BE29 Developmental disorders of the brain, learning disorders, learning difficulties. Speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

BE30 The costs of:

- cosmetic, reconstructive or remedial treatment; or
- replacing any implant;

including any related complications, whether or not the treatment, replacement or complications are for psychological reasons.

We will pay these costs if an in-patient or daycare surgical operation is needed as the result of an eligible medical condition that first occurred after your date of joining.

BE31 Removing fat from any part of the body, breast reduction or breast enlargement.

BE32 Treatment in a quarantine, isolation ward or unit, nursing home, hydro spa, spa, health farm or similar facility unless stated otherwise in the Table of Benefits

BE33 Charges incurred for overdue payment of invoices.

BE34 Myopia, hypermetropia, astigmatism, natural or non-medical degenerative sight or hearing disorders, aids to help with your sight or hearing, contact lens solutions, eye drops, sunglasses or prescription sunglasses. Preventative services and examinations for sight or hearing.

BE35 Treatment needed as a result of tattooing or piercing any part of the body.

BE36 Dental veneers and any related procedures.

BE37 Compulsive or addictive eating disorders or homesickness.

BE38 Obesity, special diet or weight control.

BE39 Costs of:

- vitamin, mineral or organic supplements;
- children's food or baby supplies; or
- products that can be obtained without a prescription, including, but not limited to, mouthwash, toothpaste, antiseptic lozenges or sprays, shampoo and sunscreen.

BE40 Costs for medical aids that form part of palliative care or long-term care.

BE41 Costs of:

- completing Claim forms
- completing or obtaining any other documents
- translation of medical reports or other documents

If you receive treatment outside Thailand, we will not pay any registration fees or service administration fees, including concierge and interpreter services.

BE42 Any consequential loss, including but not limited to:

- loss of earnings while unable to work due to illness or injury
- additional childcare costs incurred while you are admitted to hospital
- additional local travel costs incurred due to illness or injury
- parking fees at the hospital or clinic
- delivery, shipping or postage and packing costs of any kind

BE43 Costs incurred before your start date or after your end date.

BE44 Costs incurred for consultations, treatment, medication or therapy when received outside of the policy period, regardless of the date prescribed by a medical professional.

BE45 Any costs relating to in-patient, daycare or out-patient treatment in a hospital:

- received at the time of your start date; or
- that you were aware of at your start date;

whether the treatment was planned or not, unless you have told us about it and we have accepted it.

BE46 Drugs or dressings that:

- are not recognised by the pharmaceutical regulator in the country where treatment is provided;
- are available without prescription; or
- are prescribed for a medical condition that is different to the one that you are claiming for.

BE47 Costs as a result of proven medical negligence or malpractice.

BE48 Any deductible that applies to your plan.

BE49 Costs of:

- contraception or sterilisation;
- treatment for sexual problems, including impotence, whatever the cause;
- fertility or infertility tests or treatment;
- assisted reproduction; or
- surrogacy.
- surrogacy.

BE50 Invoices, Claim forms, medical reports or any other documents that have been altered or amended.

BE51 Travelling in, or on, a motorised vehicle as a driver or passenger:

- if the driver does not have a valid licence as required by local law; or
- you are not wearing the necessary safety equipment.

BE52 Health education programmes or services including, but not limited to, family planning, antenatal classes and parenting classes.

BE53 Treatment of birthmarks.

BE54 Injuries caused by professional, extreme sports or Hazardous pursuit: Treatment or diagnostic procedures for injuries arising from taking part in professional sports or hazardous pursuits, including but not limited to:

- Mountain sports such as abseiling, mountaineering and racing of any kind (except for racing on foot).
- Snow sports such as bobsleigh, luge, mountaineering, skeleton, skiing off-piste and snowboarding off-piste.
- Equestrian sports such as hunting on horseback, horse jumping, polo, steeple chasing or horse-racing of any kind.
- Water sports such as potholing (solo caving) or cave diving, scuba diving to a depth of more than 10 metres, high diving, white water rafting and canyoning.
- Car and motorcycle sports such as motorcycle riding and quad biking.
- Combative sports.

- Air sports such as flying with a microlight, ballooning, hang gliding, paragliding, parascending and parachute jumping.
- Various other sports such as bungee jumping.

Additional Benefit Conditions for Maternity Module

Benefit conditions

Claims will only be paid under the plan if you meet the benefit conditions listed in the 'Benefit Conditions' section. No claims against the maternity benefits will be paid until a 16-month waiting period has been served. Please also refer to 'Start Dates for Added Dependants' for more information.

Additional Benefit Conditions for Personal Accident Module

Benefit conditions

Claims will only be paid under the plan if you meet benefit condition BC13 in the 'Benefit conditions' section and the extra benefit conditions listed below.

BCPA1 In the event of permanent disablement or death due to accident, a percentage of the sum insured will be paid as follows:

- **Accidental death (payment made to insured's beneficiary)**	**100%**
- **loss of sight of both eyes**	**100%**
- **loss of the use of both hands or both arms**	**100%**
- **loss of the use of both feet or both legs**	**100%**
- **loss of the use of one arm and one leg**	**100%**
- **loss of sight of one eye**	**50%**
- **loss or loss of use of one foot or one leg**	**50%**
- **loss or loss of use of one hand or one arm**	**50%**

BCPA2 We provide cover for managerial, clerical and administrative occupations only. If you engage in any manual or dangerous occupation or hazardous pursuit which puts you at greater risk of a bodily injury caused by an accident, the planholder must tell us. We will tell the planholder if we agree to cover you and let them know any extra premium that applies.

BCPA3 No amount above the maximum accumulation limit shown on the Table of benefits will be paid for claims arising from any one event in any one location or vehicle, if they are made by multiple members on the same Personal accident module. If the total value of claims exceeds the maximum accumulation limit, the amount paid for each claim will be reduced proportionately to the amount each member is due, up to the maximum accumulation limit.

BCPA4 You will not be paid more than the overall maximum limit for each unit shown in the Table of benefits for any one or more accidents.

BCPA5 If you suffer one or more permanent total or permanent disablements within 12 months of an accident, you will only be paid up to the benefit limits shown on your Table of benefits that applied in the plan year when you had the accident. You will not be paid any more than the overall limit shown on your Table of benefits.

BCPA6 If you die within 12 months of an accident, payment will only be made up to the benefit limit shown on your Table of benefits that applied in the plan year when you had the accident, in line with the instructions received from your personal representative. If you die before any disablement benefit is paid, only the accidental death benefit will be paid.

If any disablement benefit has already been paid under this plan for any accident that happened in the same plan year, the accidental death benefit amount paid will be reduced by the value of any claims already paid.

No payment will be made for any more than the overall limit shown on your Table of benefits.

BCPA7 We must be told as soon as possible about any accident that causes or may cause a claim.

BCPA8 Cover is not provided for sickness or disease.

BCPA9 You must make all medical records, notes and correspondence we need available to us, and any medical advisor we have appointed.

BCPA10 For any claim to be considered for loss of sight of both eyes, you must be diagnosed as blind on the authority of a fully qualified ophthalmic specialist.

BCPA11 For any claim to be considered for loss of sight of one eye, the degree of sight after correction must be 3/60 or less on the Snellen Scale, seeing at 3 feet what you should see at 60 feet, or an equivalent scale.

BCPA12 If you have an existing medical condition and suffer a bodily injury because of an accident, we will ask an independent specialist to assess if your existing medical condition has contributed to your disability after the accident, or if your disability after the accident has made your existing medical condition worse. We will decide the difference between your existing medical condition and the disability suffered after the accident and pay any claim based on this difference. This will be expressed as a percentage and applied to the appropriate benefit.

An example of this is:

You are partially deaf in your right ear. You have an accident that causes total permanent loss of hearing in your right ear.

We will ask an independent ENT specialist to assess the difference between the level of deafness you had before and after the accident. If the independent ENT specialist advises that the deafness in your right ear before the accident was at 25%, you will be paid 75% of your benefit limit for total deafness of one ear.

Benefit exclusions

The Personal accident module does not cover claims for, arising from or connected with the benefit exclusions, BE2 to BE3, BE9 to BE12, BE21 to BE25, BE27, BE40, BE41, BE45 and BE50 listed in the 'Benefit exclusions' section and the extra benefit exclusions listed below.

BEPA1 Aviation other than as a fare-paying passenger in a fully-certified passenger carrying aircraft, flown in the course of licensed operation for transporting passengers by licensed crew.

BEPA2 Engaging in manual or dangerous occupations, professional sports or hazardous pursuits including, but not limited to:

- Mountain sports such as abseiling, mountaineering and racing of any kind (other than on foot).
- Snow sports such as bobsleigh, luge, mountaineering, skeleton, skiing off-piste and snowboarding off-piste.
- Equestrian sports such as hunting on horseback, horse jumping, polo, steeple chasing or horse-racing
- of any kind

  Water sports such as potholing (solo caving) or cave diving, scuba diving to a depth of more than
- 10 metres, high diving, white water rafting and canyoning.
- Car and motorcycle sports such as motorcycle riding and quad biking.
- Combative sports.

  Air sports such as flying with a microlight, ballooning, hang gliding, paragliding, parascending,
- and parachute jumping.

  Various other sports such as bungee jumping.

BEPA3 Any accident that happens before your start date or after your end date.